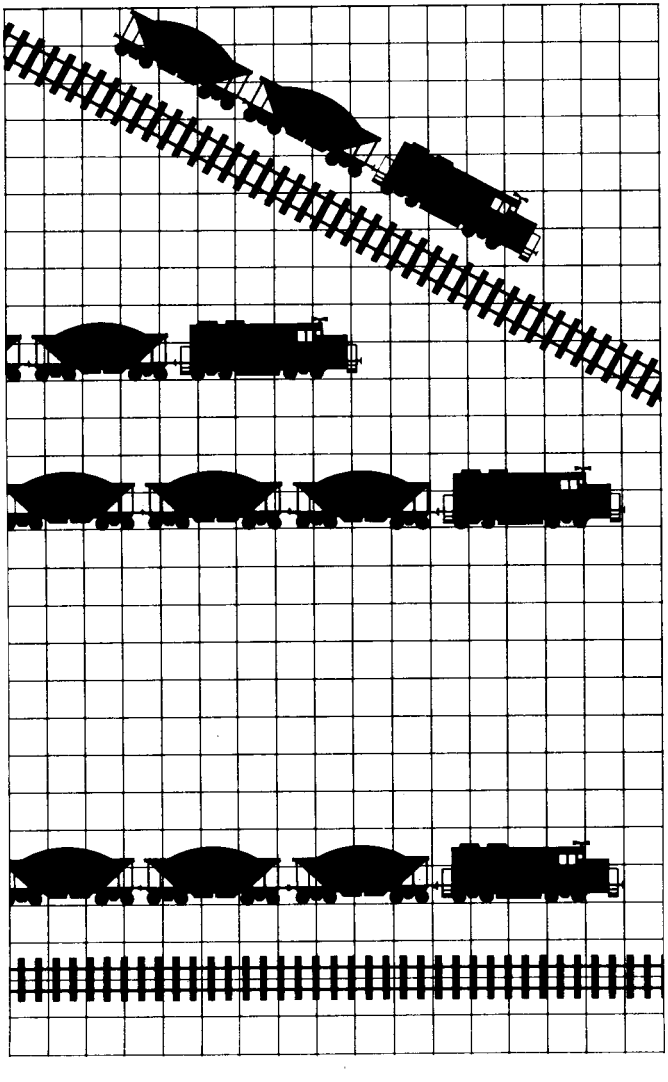
# Medicare

## for Railroad Workers and Their Families



# U.S. Railroad Retirement Board

**Glen L. Bower,** Chairman

**V. M. Speakman, Jr.,** Labor Member

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## *Mission Statement*

The primary mission of the Railroad Retirement Board is to administer the Railroad Retirement and Railroad Unemployment Insurance Acts, and to assist in the administration of the Social Security Act and the Internal Revenue Code.

## *Policy Statement on Quality*

In carrying out our mission, the Railroad Retirement Board will strive to pay benefits to the right people, in the right amounts, in a timely manner, treat every person who comes into contact with the agency with courtesy and concern, and respond to all inquiries promptly, accurately, and clearly. The Railroad Retirement Board will maintain a work environment characterized by teamwork, respect, and a commitment to doing the job right the first time.

## Why you should read this booklet . . .

Sooner or later, nearly everyone will be affected by Medicare, the nation's major Federal health insurance program. In fact, if you pay taxes, you're already affected by Medicare because a portion of your taxes goes to finance part of the Medicare program.

Even though you're paying into the Medicare program during your working years, and will probably rely on its services in the future, you may not be aware of what benefits the program offers--and what it doesn't offer. The basic information in this booklet will give you an overview of the Medicare program. If you want detailed information or are interested in a specific part of the program, you'll need to get a copy of *Your Medicare Handbook*. The *Handbook* is mailed to Medicare beneficiaries when they become eligible for the coverage.

## What's Inside . . .



This booklet is issued for the purpose of general information. Certain limitations, exceptions and special cases are not covered.

# What is MEDICARE ?

Medicare is our country's health insurance program for people age 65 or older, certain people with disabilities who are under 65, and people of any age who have permanent kidney failure. It provides basic protection against the cost of health care, but it doesn't cover all your medical expenses, nor the cost of most long-term care. You can choose one of two ways to get benefits under Medicare: the traditional fee-for-service system or the managed care program. To help you decide which way is best for you, read the descriptions on pages 13-15 starting with *Medicare Options*.

The Health Care Financing Administration is the agency in charge of the Medicare program. But we--the staff of the Railroad Retirement Board--help you enroll in the program and give you general Medicare information.

## Medicare has two parts:

**Hospital insurance** (also called "Part A" Medicare), which is financed by a portion of railroad retirement tier I and social security payroll taxes, **and**

**Medical insurance** (also called "Part B" Medicare), which is partly financed by monthly premiums paid by people who choose to enroll.

You are automatically enrolled in Part B when you become entitled to Part A.

However, because you must pay a monthly premium for Part B coverage, you have the option of paying for the coverage or turning it down.

Each part of Medicare covers different kinds of medical costs, has different rules about enrolling, and so on. Because of these differences, the two parts of the Medicare program are described separately in many sections of this booklet.

## A word about Medicaid

Many people think that Medicaid and Medicare are two different names for the same program. Actually, they are two different programs. Medicaid is a State-run program designed primarily to help those with low income and little or no resources. The Federal Government helps pay for Medicaid, but each State has its own rules about who is eligible and what is covered under Medicaid. Some people qualify for both Medicare and Medicaid. For more information about the Medicaid program, contact your local social service or welfare office.

# Who can get Medicare and how to sign up

## Hospital insurance

### If you are 65 or older

Most people 65 or older are eligible for Medicare hospital insurance (Part A) based

on their own--or their spouse's--employment. You are eligible at 65 if you receive railroad retirement or social security benefits, or you are not getting railroad retirement or social security benefits, but you have worked long enough to be eligible for them.

## If you are under 65

Before age 65, you are eligible for Medicare hospital insurance if you have been entitled to monthly benefits based on **a total disability** for at least 24 months.

## Eligibility for family members

Under certain conditions, your spouse, divorced spouse, surviving divorced spouse, widow or widower, or a dependent parent may be eligible for hospital insurance when he or she turns 65, based on your work record.

Also, disabled widows and widowers under 65, disabled surviving divorced spouses under 65, and disabled children may be eligible for Medicare, usually after a 24-month qualifying period.

## If you have kidney failure

There are special rules for people with permanent kidney failure. Under these rules, you are eligible for hospital insurance **at any age** if you receive maintenance dialysis or a kidney transplant **and** you are insured or are getting monthly benefits under the railroad retirement or social security system.

In addition, your spouse or child may be eligible, based on your work record, if she or he receives continuous dialysis for permanent kidney failure or had a kidney transplant, even if no one else in the family is getting Medicare.

### If you do not qualify under these rules

Certain aged or disabled people who do not qualify for Medicare hospital insurance under these rules may be able to get it by paying a monthly premium. See page 8 for information about buying hospital insurance.

## Medical insurance

Almost anyone who is 65 or older--or who is under 65 but eligible for Medicare hospital insurance--can enroll for Medicare medical insurance by paying a monthly premium (more on this on pages 6-8).

## Help for low-income Medicare beneficiaries

If your income and assets are very limited, you should know about programs that can help save you money. One is the "Qualified Medicare Beneficiary" or "QMB" program. The other is the "Specified Low-Income Medicare Beneficiary" or "SLMB" program. Both programs are run by the Health Care Financing Administration and the State agency that provides medical assistance under the Medicaid program.

They differ in the amount of income that qualifies you for help.

If you qualify for the QMB program, your State will pay your monthly Medicare premiums. You will not have to pay the Medicare deductibles and coinsurance, which can save you a lot more money. If you qualify for the SLMB program, your State will pay only for your medical insurance (Part B) monthly premium.

The rules vary from State to State. In general, you may qualify for help from the QMB or SLMB program if:

- your income is limited; and
- your "resources" do not exceed

certain limitations. (Resources are things you own. But some things don't count. For example, the house you live in and some other things, such as a car, may not count.)

Only your State can decide if you qualify for help under the QMB or SLMB program. To find out if you qualify, contact your State or local medical assistance (Medicaid) agency, social service office, or welfare office.

## Signing up for Medicare

If you're already getting railroad retirement or social security checks, we'll contact you a few months before you become eligible for Medicare and give you the information you need to sign up.

If you aren't already getting checks, you

should contact us about 3 months before your 65th birthday to sign up for Medicare. You can sign up for Medicare even if you don't plan to retire at 65.

You should contact the Railroad Retirement Board about applying for Medicare if:

- you're a disabled widow or widower between 50 and 65 but haven't applied for disability benefits because you're already getting another kind of benefit;
- you, your spouse, or your dependent child has permanent kidney failure (contact a social security office in these cases to see if you are eligible);
- you had Medicare medical insurance in the past but dropped the coverage; or
- you turned down Medicare medical insurance when you became entitled to hospital insurance.

Initially, you have 7 months to sign up for medical insurance (Medicare Part B). This 7-month period begins 3 months before the month you first meet the requirements for Medicare, includes that month, and ends 3 months after the month you meet the requirements. If you enroll during the first 3 months of your enrollment period, your medical insurance protection will start with the month you are eligible. If you enroll during the last 4 months, your protection will start 1 to 3 months after you enroll. If you don't enroll during this initial enroll-

ment period, each year you are given another chance to sign up during a general enrollment period from January 1 through March 31. Your coverage begins the following July. Your monthly premium increases 10 percent for each 12-month period you were eligible but didn't enroll. See pages 17-19 if you are covered by an employer group health plan.

If you're 65 or older and don't qualify for Medicare, you can buy Part A coverage, much like private insurance, for a monthly premium ($311 or $187 per month in 1997, depending on your work history). If you want to buy Part A hospital insurance, you must enroll in Part B and pay a monthly premium for that coverage as well ($43.80 per month in 1997). If you wait to buy Part A hospital insurance, the enrollment periods are the same as those for Part B, discussed above.

## What Medicare covers

The two parts of Medicare are designed to help pay for different kinds of health care costs. Some kinds of health care aren't covered by Medicare at all.

### Medicare hospital insurance benefits

Medicare hospital insurance can help pay for inpatient care in a hospital or

skilled nursing facility following a hospital stay, home health care, and hospice care. Except for home health care, each is subject to a benefit period, which measures your use of services covered by Medicare Part A.

A benefit period starts the day you enter a hospital. It ends when you have been out of the hospital or other facility primarily providing skilled care for 60 days in a row. If you remain in such a facility (other than a hospital), a benefit period ends when you have not received any skilled care there for 60 days in a row. There is no limit to the number of benefit periods for hospital and skilled nursing facility care. But special limits do apply to hospice care. (See *Hospice care* on page 11.)

## Inpatient hospital care

If you need inpatient care, hospital insurance helps pay for up to 90 days in any Medicare-participating hospital during each benefit period. In 1997, hospital insurance pays for all covered services for the first 60 days, **except for the first $760**. For days 61 through 90, hospital insurance pays for all covered services **except for $190 a day in 1997.**

If you are out of the hospital for at least 60 days in a row, and then go back in, a new benefit period begins--your 90 days of coverage starts all over again, and you pay another deductible.

What if you need more than 90 days of inpatient care during any benefit period? You can use some or all of your "reserve

days." Reserve days are an extra 60 hospital days you can use if your illness keeps you in the hospital for more than 90 days. You have **only** 60 reserve days in your lifetime, and you decide when you want to use them. For each reserve day you use, hospital insurance pays for all covered services **except for $380 a day in 1997**.

## Skilled nursing facility care

If you need inpatient skilled nursing or rehabilitation services after a hospital stay and you meet certain other conditions, hospital insurance helps pay for up to 100 days in a Medicare-participating skilled nursing facility in each benefit period.

Hospital insurance pays for all covered services for the first 20 days. For the next 80 days, it pays for all covered services **except for $95 a day in 1997.**

**Note.--**It is important to know that Medicare **does not** pay for "custodial care" when that is the only kind of care that you need. Custodial care is the type of care many people receive in nursing homes. It is care that **could** be given by someone who is not medically skilled (for example, help with dressing, walking, or eating).

## Home health care

If you are confined at home and meet certain other conditions, Medicare can pay the full approved cost of home health visits from a Medicare-participating home health agency. There is no limit to the number of covered visits you can have.

If you need one or more of the covered services, then hospital insurance also covers part-time or intermittent services of home health aides, different kinds of therapy, medical social services, and medical supplies and equipment. A 20-percent copayment applies to covered durable medical equipment (e.g., wheelchairs and hospital beds).

### Hospice care

A hospice program provides pain relief and other support services for terminally-ill people. Medicare hospital insurance can help pay for hospice care for terminally-ill beneficiaries if the care is provided by a Medicare-certified hospice and certain other conditions are met.

Hospital insurance can pay for hospice care for up to 210 days, or even longer in some cases.

## Medical insurance benefits

Medicare medical insurance helps pay for doctors' services and many medical services and supplies that are not covered by the hospital insurance part of Medicare, such as ambulance services, outpatient hospital care, and X-rays.

### Deductible

Each year, before Medicare medical insurance begins paying for covered services, you must meet the annual medical insurance "deductible." (A deductible is the amount a beneficiary must pay before

Medicare begins paying.) In 1997, the annual deductible is $100. After you meet the deductible, Medicare will generally pay 80 percent of the approved charges for covered services during the rest of the year.

## What Medicare does not cover

Medicare provides basic health care coverage, but it doesn't pay all of your medical expenses. Here are examples of what Medicare **does not** pay for:

- "custodial care" (This is care that **could** be given safely and reasonably by a person who is not medically skilled, and which is given mainly to help the patient with daily living. Examples include help with walking, bathing, and dressing. Even if you are in a participating hospital or skilled nursing facility, or you are getting care from a participating home health agency, Medicare **does not** cover the cost of care if it is mainly custodial.)
- most nursing home care
- services outside the United States (Hospital services in Canada are covered by Medicare. Medical services in Canada and hospital and medical services in Mexico may be covered but only under very limited conditions.)
- dental care and dentures
- routine checkups and the tests directly related to these checkups (except that some screening, Pap smears and mammograms are covered)

■ most immunization shots (Part B helps pay for flu and pneumonia shots.)

■ most prescription drugs

■ routine foot care

■ tests for, and the cost of, eyeglasses or hearing aids

■ personal comfort items, such as a phone or TV in your hospital room

## Medicare options

Medicare beneficiaries may now choose how they'll receive hospital, doctor, and other health care services covered by the program. And, your choice may affect the amount of money you pay for these services.

Most people use the traditional "fee-for-service" delivery system--visiting the hospital or doctor of their choice and paying a fee each time they use a service. But more and more people are turning to managed care plans that feature comprehensive coverage of services offered by a network of health care providers. Medicare coverage is the same under both systems. The differences include how the benefits are delivered, how and when payment is made, and the amount of "out-of-pocket" expenses required.

### Fee-for-service systems

Under fee-for-service systems, Medicare pays a set percentage of a beneficiary's hospital, doctor, and other health care expenses, and the beneficiary is responsible for cer-

tain deductibles and "coinsurance" payments (the portion of the bill Medicare does not pay). Most people covered under a "fee-for-service" Medicare plan also purchase private insurance--usually called "Medigap"--or have retiree coverage available from their former employer or union to supplement their Medicare coverage (see pages 17-19).

## Managed Care Plans

Managed care plans (sometimes called HMOs) that have contracts with the Medicare program must provide all hospital and medical benefits covered by Medicare. However, usually you must obtain services from your plan's network of health care providers (doctors, hospitals, skilled nursing facilities, for example). In most cases, for services not authorized by your plan (except emergency services or services urgently required while you are out of the plan's service area) neither the plan nor Medicare will pay for these services. If you enroll in a plan that has a contract with Medicare, the plan will receive a monthly payment from Medicare and you will have to enroll in Medicare Part B and continue to pay your Part B monthly premium. Most plans charge a monthly premium for enrollees in addition to a small copayment each time you use a service. Usually, no additional charges are made no matter how many times you visit the doctor, are hospitalized, or use other covered services.

Many plans that have contracts with the Medicare program also provide benefits beyond those Medicare pays for. These include preventive care, prescription drugs, dental care, hearing aids, and eyeglasses. The benefits may vary by plan and you'll need to read the individual descriptions to determine which benefits are offered by each.

## What if you think you need more insurance?

Traditional "fee-for-service" Medicare coverage provides basic health care coverage, but it can't pay all of your medical expenses, and it doesn't pay for most long-term care. For this reason, many private insurance companies sell insurance to fill in the gaps in Medicare coverage. This kind of insurance is often called "Medigap" for short. However, Medigap insurance is usually not needed if you use a managed care plan (see above).

The Health Care Financing Administration publishes a booklet with information on supplementing Medicare coverage. It's called *Guide to Health Insurance For People With Medicare* (Publication No. HCFA 02110) and is available by writing to:

**Medicare Publications**
**Health Care Financing Administration**
**7500 Security Boulevard**
**Baltimore, MD 21244-1850**

# What you should know if you have other health insurance

As we've explained, Medicare hospital insurance is free, but you pay a monthly premium for medical insurance. If you already have other health insurance when you become eligible for Medicare, is it worth the monthly premium cost to sign up for Medicare medical insurance?

The answer varies with the individual, and the kind of other health insurance. While we can't give you "yes" or "no" answers, we can offer a few tips that may be helpful when you make your decision.

## If you have a private insurance plan

Get in touch with your insurance agent to see how your private plan fits--or "integrates"-- with Medicare medical insurance. This is especially important if you have family members who are covered under the same policy. And remember, just as Medicare doesn't cover all health services, most private plans don't either. In planning your health insurance coverage, keep in mind that most nursing home care is not covered by Medicare or private health insurance policies. One important word of caution: For your own protection, **don't cancel any health insurance you now have until your Medicare coverage actually begins.**

## If you have health insurance from an employer group health plan

In this case, there are some special rules you should know about:

If you are age 65 or older and are (a) currently employed or (b) married to an individual of any age who is currently employed, **and** are covered under a group health plan, you may delay enrolling in Medicare medical insurance (Part B) and enroll during a special enrollment period. The rules allow you to enroll any time while you are covered under the group health plan or during a special 8-month period that begins with the month your group health coverage ends or the month employment ends--whichever comes first. If you meet the requirements, you may not have to wait for a general enrollment period, and you may not have to pay the premium surcharge for late enrollment in Medicare. If, however, the coverage or employment ends during the last 4 months of the initial enrollment period and you enroll for Medicare medical insurance during this period, protection will be delayed 1 to 3 months (see pages 7-8).

**Group health plans of employers with 20 or more employees are required by law** to offer workers who are 65 (or older) the same health benefits that are provided to younger employees. They must also offer the spouses who are 65 (or older)--of work-

ers of any age--the same health benefits given younger spouses.

If you are 65 or older and have current employment--or you are 65 or older and are the spouse of a person who has current employment--and you accept the employer's health insurance plan, Medicare will be the **secondary payer.** This means the employer plan pays first on your hospital and medical bills. If the employer plan does not pay all of your expenses, Medicare may pay secondary benefits.

If you reject the employer's health plan, Medicare will be the primary health insurance payer. The employer is **not** allowed to offer you Medicare supplemental coverage if you reject his or her health plan.

When you enroll in Medicare Part B at or after age 65, you will trigger your one-time Medigap open enrollment period. If you enroll in Part B while you are covered under an employer plan that is the primary payer, you may not need a Medigap policy. Your Medicare Part B will be the secondary payer and your employer will be the primary payer. Later, when you are no longer covered by your employer plan, you may not be able to purchase the Medigap plan of your choice because your Medigap open enrollment period will have expired.

If on the other hand, you delay Part B enrollment until your primary employer plan coverage is about to stop, you will be able to use your open enrollment period to your best advantage. During open enrollment, you may purchase any Medigap plan

from any company at its most favorable price for your age group. During this period, you can purchase policies that cover outpatient prescription drugs, which generally are not available outside of the open enrollment period unless you are healthy.

**If you are under 65 and disabled, and you are currently employed or are the family member of a person who has current employment, and you have health coverage under a "large group health plan,"** Medicare will be the secondary payer. A large group health plan covers employees of an employer or group of employers of which at least one employer has 100 or more workers. If that's the case, you will also have special enrollment period and premium rights that are similar to those for workers 65 or older.

**If you are entitled to Medicare because of permanent kidney failure and you have employer group health coverage,** Medicare will be the secondary payer for the first 18 months of your Medicare Part A eligibility or entitlement. At the end of the 18-month period, Medicare becomes your primary payer.

## If you have health care protection from other plans

**If you have health care protection from the Indian Health Service, Department of Veterans Affairs or a State medical assistance program,** contact the people in those offices to help you decide

whether it is to your advantage to have Medicare medical insurance.

## Questions?

We've covered a number of difficult rules. If you aren't sure if any apply to you, contact the nearest Railroad Retirement Board office for help. (But if you aren't sure about the size of the employer group health plan, check with the personnel office of the employer.)

## NONDISCRIMINATION ON THE BASIS OF DISABILITY

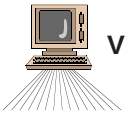
Under Section 504 of the Rehabilitation Act of 1973 and Railroad Retirement Board regulations, no qualified person may be discriminated against on the basis of disability. The Board's programs and activities must be accessible to all qualified applicants and beneficiaries, including those who are vision or hearing-impaired. Disabled persons needing assistance (including auxiliary aids or program information in accessible formats) should contact the nearest Board office. Complaints of alleged discrimination by the Board on the basis of disability must be filed within 90 days in writing with the Director of Equal Opportunity, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611-2092. Questions about individual rights under this regulation may also be directed to the Board's Director of Equal Opportunity.

## FRAUD AND ABUSE HOT LINE

Call the toll-free Hot Line if you have reason to believe that someone is receiving railroad retirement or unemployment-sickness benefits to which he or she is not entitled; or that persons responsible for the financial affairs of minors or incompetent beneficiaries are misappropriating benefits.

You may also use the Hot Line to report any suspected misconduct by a Railroad Retirement Board employee. The Hot Line has been installed by the Railroad Retirement Board's Inspector General to receive any evidence of such fraud or abuse of the Board's benefit programs. The toll-free Hot Line number nationwide is 1-800-772-4258. Or you may send your complaints in writing to RRB, OIG, Hot Line Officer, 844 North Rush Street, Chicago, Illinois 60611-2092. Please do not call the Inspector General's Hot Line with questions about eligibility requirements, delayed claims, or similar problems. Such matters should be directed to the nearest Railroad Retirement Board office.

If you have reason to believe that a doctor, hospital, or other provider of health care services is performing unnecessary or inappropriate services or is billing Medicare for services you did not receive, call the Department of Health and Human Services Hot Line at 1-800-HHS-TIPS.



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